Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Centennial Medical Center

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-14-1782-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 20, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 03/01/2008…"

Amount in Dispute: $72.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our Fee Schedule team has determined that no further payment is due at this time to the provider for the following reason: We have found that when the provider previously appealed, the charges were denied as: Reconsideration request date (s) of ser exceed 10 month period for submission per Rule 133.250(b). We found no specific proof of timely filing attached to the reconsideration or the dispute."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2013	96372	$72.83	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets the guidelines for reimbursement of medical services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - W3 – Request for reconsideration
   - 193 – Original payment decision is being maintained. It was determined that this claim was processed correctly

Issues

1. Did the requestor support additional reimbursement is due?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.403.(d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section"… National Correct Coding Initiative Policy Manual, Chapter 11, Section (B), (7) states, "Under OPPS, hospitals may report drug administration services (CPT codes 96360-96376) and chemotherapy administration services (CPT codes 96401-96425) with facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code." Review of the supporting documentation found no documentation to support the drug administration was significant and separately identifiable from the Emergency Department Visit (99283) "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity."
2. Carrier states reconsideration was not timely. The Division finds nothing to support this statement. However, based on provisions of Rule 134.203 no separate payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 19, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.